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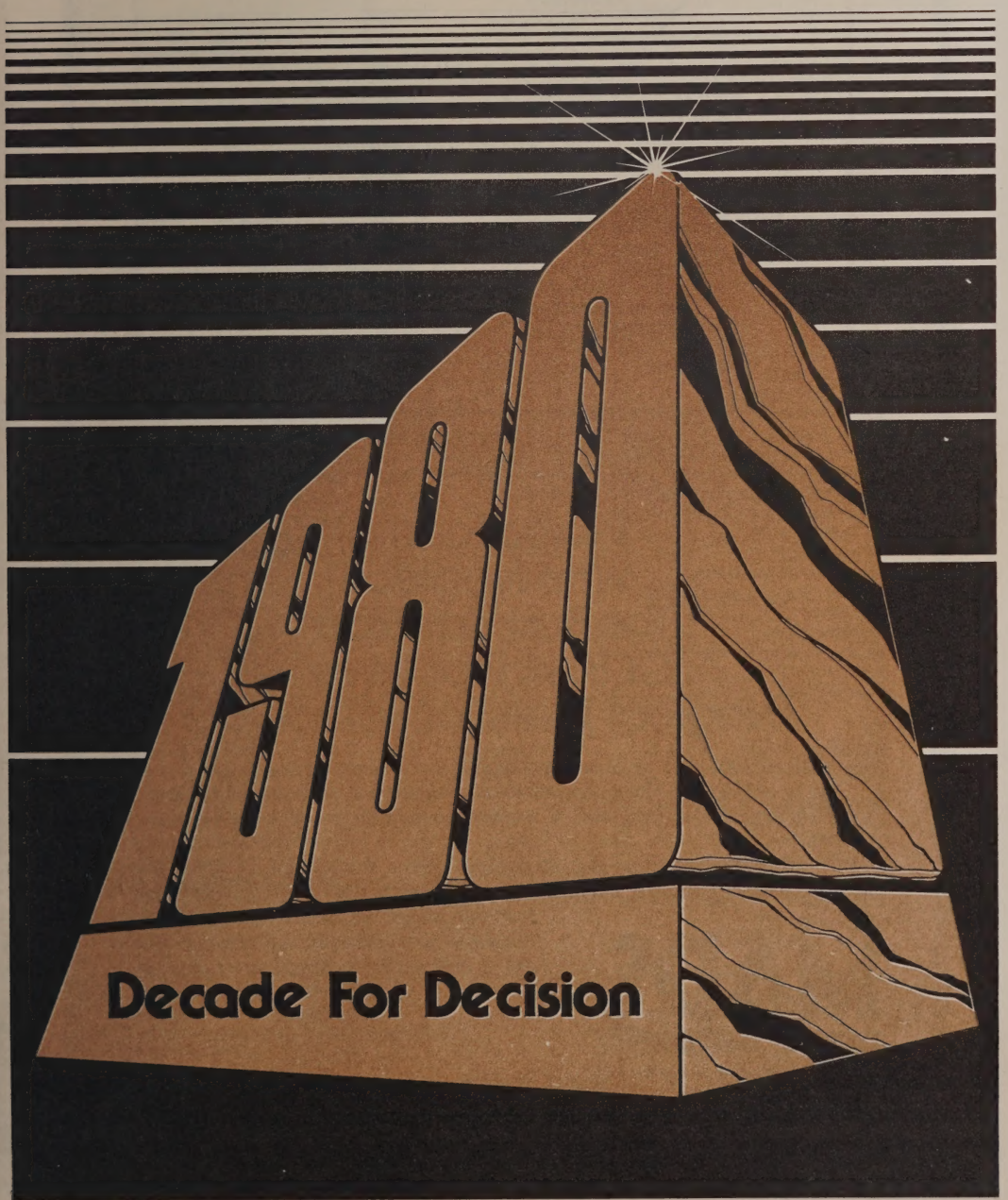
JANUARY 1980



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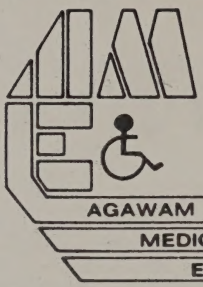

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JANUARY 1980

HAPPY AND HEALTHY NEW YEAR

District Meeting

What? Meeting of the Hampden District Medical Society.

When? Monday, February 11, 1980
(notice change of date)

Where? Marriott Hotel
Main Street, Springfield (validated parking)

Business Meeting: 6:00 P.M.

Social Hour: 7:00 P.M.

Dinner: 7:30 P.M. (Courtesy of HDMS for members.)

Speaker: James H. Sammons, M.D.
Executive Vice President, American Medical Association

Spouses are invited to attend this meeting. Cost for guests $10.50. Please remit checks with reservations.

Note:

If you must cancel your dinner reservations, all the office before noon of November 27th. If the cancellations are not made you will be billed for your dinner.

Smoking in designated areas only at dinner.

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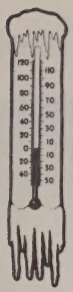

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of The Massachusetts
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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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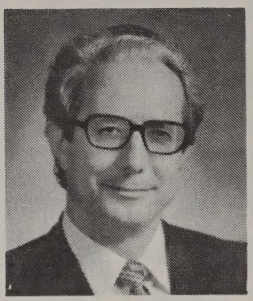

PRESIDENT'S PAGE

A LOOK INTO 1980

In the January 1979 issue of the "Hippocrat" our past President Dr. John Flahive, in a skilled editorial, launched himself into a set of predictions many of which ended up being indeed correct. Let us try to do something similar and let us try together to look into the crystal ball.

In Washington, we still observe an atmosphere of relief following the defeat of the Hospital Cost Containment bill. There is no doubt that if there is less federal involvement, the better the results will be. It will be up to us to demonstrate in 1980 that voluntary cost control is effective and here, in our District, we urge implementation of cost and quality control studies, cost containment teaching to the house staff of our hospitals and increased decision making power of "cost containment committee".

Obviously, no National Health billis going to be passed this year but there is a weak spot that is up to us to erase. The bill will not be voted essentially because of its cost, and the fear on the part of our Congress of an overwhelming expenditure. This is true, but it is up to us to demonstrate that outside of the cost, it is the fee delivery of health care which provides the best patient care as well.

The catastrophic Health Insurance bill, generated by a strange alliance between President Carter and Senator Long, will instead pass. It may be so that at the end of this year a great portion of the American people will have "catastrophic illness insurance" while fewer than 60% have it today. There will be no "ceiling" that is, no maximum beyond which the insurance does not pay. There is actually no such "ceiling" today, except in the contract. As every hospital knows, charges not covered by the catastrophic illness policy are not collectable.

Switching from Washington to Boston, we will probably hear this year of some restrictions imposed from our State legislators on the use of psychotropic drugs with an increase in the list of the medicines labeled as narcotics.

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We will see, in addition, a debate of the infamous Medicaid bill. The 30% reduction which the State legislature wants to see imposed on the meager increase presently considered is beyond our degree of tolerance. At the State Society level but also at the level of our own District, a constant and persistent visibility of our points of view will be organized. To this effect, I make an appeal to our membership "in toto" as each and everyone may be called upon for help in this battle and indeed if united, logic and intelligence will overcome demagoguery and populism.

At the very beginning of 1980, we will be busy rescuing those of our colleagues not in line with the required CME credits sufficient for relicensing. Help will be provided both by our offices here and by a special office set up for this purpose in Boston by our State Society.

In 1980 we will see our suit against the Blues still pressed forward, but it may be 3 years before we reach its end.

Local, State and National Health Planning Councils will appear more and more as decision making authorities. In addition to their reviewing of plans and providing certificates of need, these councils will also represent economical powers as assignment of grants for many a study will stem from their opinions. We urge our members to particpate and attend the local meetings of the HSA's and our office will provide information concerning time and location of these sessions always open to the public and open to comments from the floor.

Let us try to see through the smoke of these sham battles now and indeed the future American health care system is rapidly emerging and some differences from the present may be predicted. The coverage of health care costs will include the catastrophic illness insurance perhaps with emphasis on a fairly high deductible and on some coinsurance feature up to a certain amount or to a certain percentage of the insured's family income. There will be a pluralism of health care delivery with increased options for IPA's or HMO's but there will be also an increase in the Group type of practice, and it is the private physician practicing in a group who will continue to carry the bulk of patient health care. We will see also increased organized control as well as self control of medical standards and health care costs. Peer review of doctors by doctors will grow because of malpractice suits and government pressure. Coming even faster is the systematic review of hospital costs by Blue Cross and other insurers as well as employers and large unions.

Because or despite of all this, I am sure that the American health care system will still remain the best in the world at the end of this year and for many years to come. □

FRANCO NAVAZIO, M.D.
President

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A.M.A. Interim Meeting, 1979

The current custom of the American Medical Association is to have an annual meeting of the House of Delegates in Chicago in July and an interim meeting in some other city. The core of the meeting is the House of Delegates, currently 277 in number, which meets for about 15 hours to review the recent activities of the Board of Trustees and AMA councils and to provide direction for future action. About 75% of the delegates are elected by their state medical associations (Massachusetts has five) and 25% represent specialty organizations. There are an equal number of alternate delegates who participate in caucus discussions, attend reference committee hearings, replace delegates on the floor of the House as needed, developing the expertise needed to be a delegate. Also attending the convention are state society officers, AMA committee members and some state society executives. They may not participate in the deliberations of the House, but they are active in reference committee hearings and in the informal deliberations that facilitate the conduct of an immense agenda. The House of Delegates elects officers and committees only at annual meetings.

The '79 interim meeting was held December 2 - 5 in Honolulu, Hawaii. The usual opening hours of the House of Delegates were advanced one hour "in deference to the salutory climate". This necessitated beginning the breakfast caucuses at 6:30 a.m. If it allowed increased recreational activities, I did not see them. I-79 was characterized by less conflict and acrimony than recent AMA meetings. This was due partly to a better understanding of the "will of the House" by the Board of Trustees. After a year or so of major philosophical and policy debates, this multifaced organization appears to have developed cohesive and well defined programs.

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The five purposes of the AMA were reaffirmed. These are: 1. To provide physicians with medical-scientific and socio-economic information relating to the practice of medicine. 2. To provide the public with timely and relevant information on health care. 3. To promote effective and efficient health care delivery without jeopardizing the quality of care delivered. 4. To represent physicians as a group to the public, industry and government. 5. To provide strong relationships within the federation and with various components of organized medicine. The proposed 1980 AMA budget allots 60% to the first two purposes futher emphasizing the AMA's significance as an educational organization.

Another force creating unity among the delegates is our "common enemy", the United States Government. Although national health insurance was hardly mentioned at I-79, the House of Delegates and senior AMA staff seemed to be looking over their shoulder constantly at federal regulatory activities. Foremost among these is the Federal Trade Commission. Contesting FTC regulations is currently costing the AMA $100,000 per month. There was constant reference to AMA actions prescribed by antitrust regulations. I counted 21 different areas where business of the House impacted on legislative, judicial or executive activities of the Federal Government. Many of these were requests for government support of health programs. Others decried government intervention. Particular concern was expressed over the increasing loss of confidentiality in the physician-patient relationship.

Although the House took action on 72 reports and 98 resolutions, there were three major reports which probably represent the most significant activities of I-79. These originated from the Council on Medical Education on the state of current medical education, the report of the Council on Long-Range Planning and the report of the ad hoc Committee on the Foreign Medical Graduate. The CME subcommittee, under the chairmanship of Dr. Perry Culver of Boston, produced 24 recommendations supported by an 80 page report. The report strongly recommended increased generalism in pre-medical, graduate and post-graduate education. Early introduction of specialty training was pronounced a failure and return to a free standing internship year strongly recommended. Compulsory continuing medical education was strongly opposed especially for relicensure. The House filed the report, approving it as an "agenda of issues" for further discussion.

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The Council on Long Range Planning once more addressed the problem of AMA membership. Although the downward trend has been reveresed, increases in AMA membership are not great enough to offset the effects of inflation on financing AMA programs. A modest dues increase is projected for 1981 or 82. The Council proposes to revise the structure of the AMA so that constituent societies will provide the financial support of the organization. Each state society will contribute dues based on the number of state society members, providing financial support from the several thousand physicians currently belonging to their state societies but not to the AMA. The relationship of specialty societies has not yet been worked out. Direct membership in the AMA will remain available for medical students, residents, military physicians and possibly some others. The House of Delegates commended the Council on its novel approach and plans to consider implementing this idea at the 1980 annual meeting.

The ad hoc Committee on the Foreign Medical Graduate has spent two years collecting information on the problems and wishes of the 20% of currently practicing American physicians who are graduates of foreign medical schools. This significant group is underrepresented in the AMA. There are two major subgroups, foreign born physicians who have immigrated to the United Sates, and United States citizens who have trained in foreign schools. The committee recommended that the first group should be better integrated in the mainstream of American medicine. The 85,000 physicians already licensed should be encouraged to increase their AMA membership and influence. The physicians who have failed to pass qualifying examinations should receive assistance in English and medical education, although only about half of these can be expected to reach qualifying standards.

The committee recommended that AMericans failing to qualify for American medical schools should be discouraged from obtaining medical education at foreign schools. However, it was not willing to recommend ending programs designed to assist those students who have already enrolled in school abroad. Dissatisfaction with the fifth pathway and COTRANS programs was noted but the recommendations stopped short of phasing them out. The committee report was referred to the Board of Trustees because of a lack of balance in parts of the report, but the data and discussion will permit action at this time. I was reminded of Dr. Rodkey's comment at the last HDMS meeting that foreign-born physicians are the most ardent spokesmen for American medicine today.

Once again, your delegates have labored on your behalf. We hope we have represented you well. We would like your support and your ideas. John Ayres and I welcome the opportunity to discuss the AMA and its actions with any member. □

GARRY deN HOUGH III, M.D.

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EXECUTIVE COMMITTEE

The Executive Committee of the Hampden District Medical Society met on Tuesday, November 20, 1979 in the Conference Room.

Present were Drs. Navazio, Flahive, Walthall, Remsberg, Stoddard, Dasco, Siragusa, Fitzpatrick and Mrs. Purdy.

Absent were Drs. Bloom, Corsar, Rich and Zadworny.

Present also were Drs. Seaver and Carey, President and Treasurer of the Springfield Academy of Medicine as well as Mrs. Martin, Executive Secretary. There are 217 members at present and dues are $60.00 per year. The problem was discussed by both interested parties. Mrs. Purdy will check records from files of the former attempt for merger and she will also contact Attorney Thomas Reardon of the Massachusetts Medical Society for other information and report back to the committee when they meet in December.

Minutes of the October meeting had been mailed out and it was voted to accept as written.

CORRESPONDENCE

1. Mrs. Purdy read a news article regarding lawyers' fees and their possibility of facing an arbitration panel which was referred to the committee by Dr. Magill. It was agreed to forward this article to Dr. Munier, Executive Vice President of the Massachusetts Medical Society and also to B.J. Anderson of the American Medical Association for an opinion using the idea for the medical profession.

2. An anonymous letter written by interested residents of Belmont Avenue was read which was concerned with NOVATAN, tanning studio located in that vicinity. The Springfield Health Dept. has looked into the legality of this. This was informational to the committee.

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OLD BUSINESS

A request from the Upper State Street Community Development Corporation for a physician to be on the Board of Directors was again discussed. It has been placed in the Newsletter to the membership and no physician has responded. A letter to this effect will be written to Mr. Fitzgerald, Project Director to this effect.

Dr. Stoddard gave a report from Dr. James Allan regarding Blue Shield's decision not to pay for laboratory studies in physician's offices not pertinent to a patients particular disease. He suggested our Insurance Committee research this with Blue Shield and report to the Executive Committee and to contact Dr. Allan for the written regulation.

Dr. Stoddard reported on liability insurance for part time physicians. It was suggested that this be discussed with the JUA at the Massachusetts Medical Society and send them a resolution to this effect. The resolution reads:

WHEREAS, physicians who retire from the active practice of medicine take into retirement their particular skills and services; and

WHEREAS, their skills and services are lost to the community and teaching programs; and

WHEREAS, these physicians often wish to contribute to the community's health care but for the lack of part time liability coverage; therefore, be it

RESOLVED, that the Massachusetts Medical Society research with the JUA the feasibility of part time liability coverage for these physicians.

Massachusetts Medical Society through Dr. Shedd has requested the Hampden District Medical Society to change billing date to January 1, 1980. Mrs. Purdy will request specific reason in writing from Dr. Shedd about this request.

Connecticut General Insurance Company informed the committee of their extensive second opinion program and this was received as informational.

Mrs. Purdy presented the FTC ruling on advertising as informational and read the American Medical Association ruling that they will try to reverse the order.

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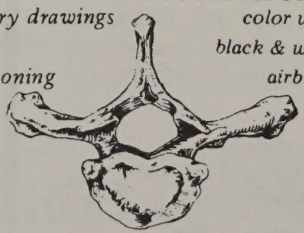
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NEW BUSINESS

Mrs. Purdy read a letter of complaint from Dr. LaMarche regarding an HMO paying a non participating hospital and not paying a non participation physician. This is to be referred to the Committee on Insurance for action and report to Dr. LaMarche.

Dr. Remsberg reported the list of physicians who are delinquent paying Hampden District Medical Society dues. They will be contacted again by Dr. Remsberg.

Dr. Stoddard attended the Rate Setting Commission Public Hearing in Boston. This was the first meeting since 1975. A 7% increase in Medicaid fees is being entertained. This is grossly below other fees.

Dr. Stoddard suggested reading an article in the Worcester Medical News by Dr. Kartell. Copies will be sent to members of the Executive Committee and Dr. Kartell will be asked if it can be printed in the Hampden Hippocrat.

Dr. Stoddard will resubmit his resolution regarding information from Thomas Reardon about the Blue Shield suit.

The meeting was adjourned at 10:35 p.m. □

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A problem arises in that the one who is confronted with the emergency is dependent on one who doesn't see it as an emergency at all.

The recourse, then, that the nursing home director must take is to threaten the physician that no more of his patients will be cared for, unless he cooperates - a significant threat, if the proprietor runs a good establishment. The doctor is left with the alternative of complying or of turning his patients over to someone else, who will cooperate, very often someone who has a hundred or more patients in that particular nursing home.

This is not meant to condemn physicians who have a large number of patients in a given nursing home, and, thus, have a closer relationship with the institution than those with just a few patients. There are certainly advantages to the nursing home, the doctor, and the patients as well. Many doctors find it impossible to visit nursing homes and should turn the patients over to others.

The point that I am making is that a number of physicians stop going to nursing homes because they object to filling out month after month - year after year a form which indicates that Mrs. Jones needs to be confined because she has a cerebral arteriosclerosis and cardiac failure. They resent having to re-certify, monthly, orders which don't change from year to the next. They resent the 'yearly physical' which they consider to be a sham. They resent, being told, how often they must see each patient - the frequency bearing no relationship to medical necessity. They resent spending five minutes with the patient and ten minutes with the forms.

Alarming to me also is the thought that (in this instance the state) more and more outside bodies are exercising their authority on others in such a way that, without any direct relationship with the physician, they can determine how, when, where, why and if he can practice. Maybe its an emergency for us, too. □

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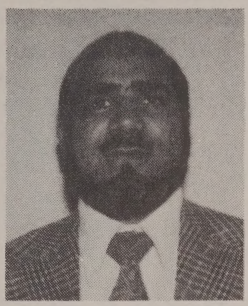
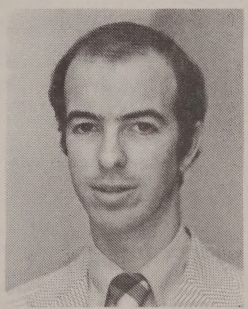


MOHAMMAD S. BAJWA, M.D. Elm Stret, Holyoke, MA Born: January 10, 1945 Medical School: King Edward Medical College, Lahore, Pakistan, 1967 Internship: St. John's Queens Hospital, N.Y. (Jan. - Dec. 1969). Residency: Catholic Medical Center, N.Y. (1970-72); Queens Hospital Center, N.Y. (1972-73). Specialty: Internal Medicine & Family Medicine.



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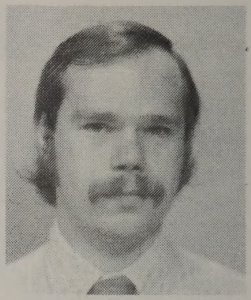
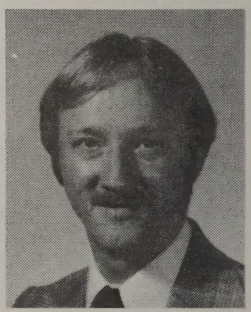


CHARLES W. CAHILL, M.D. 125 Liberty Street, Springfield, MA. Born: March 11, 1947 Medical School: Tufts University, 1974 Internship: Baystate Medical Center (1974-75). Residency: Baystate Medical Center (1975-79). Specialty: Obstetrics/Gynecology



DAVID L. CLINTON, M.D. 129 College Street, South Hadley, MA Born: March 1, 1949 Medical School: Jefferson, 1975 Internship: Medical Center, Western Mass. (1975-76). Residency: Baystate Medical Center (1976-78). Specialty: Internal Medicine.

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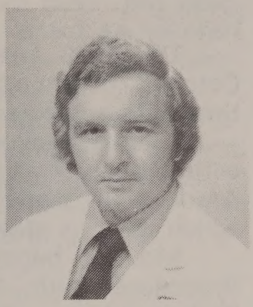
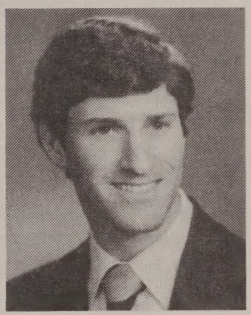
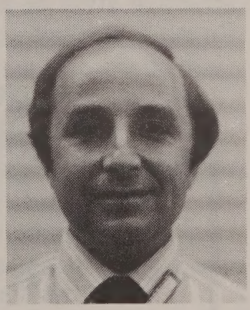


RICHARD J. FINGEROTH, M.D. 50 Maple Street, Springfield, MA Born: May 30, 1947 Medical School: Yale University, 1973 Internship: Yale New Haven Hospital, (1973-74)Residency: Yale New Haven Hospital, (1974-75); Tufts New England Medical Center (1975-76) Harvard Orthopedic Program (1976-79). Specialty: Orthopedic Surgery.



FREDERICK E. HAMPF, JR., M.D. 780 Chestnut Street, Springfield, MA Born: September 22, 1944 Medical School: Jefferson Medical College, 1970 Internship: Baystate Medical Center (1970-71). Residency: Tufts New England Medical Center hospital (1973-76). Specialty: Radiology.



BARRY Z. IZENSTEIN, M.D. 130 Maple Street, Springfield, MA Born: September 4, 1946 Medical School: University of Cincinnati 1972 Internship: University of Maryland Hospital (1972-73). Residency: Michigan State University Hospital (1973-75). Specialty: Internal Medicine & Endocrinology.

TO BE CONTINUED.....

Auxiliary Confluence

The 1979 Leadership Confluence took place in Chicago from October 7th through 9th. A great deal of material was covered in this time with subjects which were timely and well chosen.

After a delicious dinner Sunday evening our lectures commenced with James P. Low CAE, President of the American Society of Association Executives. Later we had time to see the State exhibits which gave us ideas for our own areas.

Monday began with a very moving session on Parliamentary Procedure with Russell G. Miller, J.D. Certified Professional Parliamentarian. By presenting us with a list of motions Mr. Miller stated whether one can interrupt the speaker, if a second is required, if it can be debatable, amendable, what type of vote is required, or whether it is reconsiderable. The order of business meetings and how a motion is made were discussed. It is most important that a chairman have a Parliamentarian for order as well as support.

All 500 or so of us divided up into seminars following this. My first was "The Art of People Persuasion" by Mr. J. Paige Clousson, Director, AMA Department of Negotiations, gave a very helpful lecture. The process of persuasion requires research and organization. We, as leaders should know how to deal with our opponents who fit into several different categories.

My next seminar was "Speak Up: The Articulate Woman" by Marie Kisiel, PhD., Professor of Humanities at Roosevelt University. Dr. Kisel began by giving us a workshop plan to develop a confident and effective style of speaking. By being comfortable, knowledgeable and through practice, one's speeches should improve.

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After lunch Hoyt D. Gardner, M.D., AMA President and James H. Sammons, M.D. the AMA Executive Vice President spoke. Many physicians are complaining about the rise in national dues, but how many are utilizing the AMA? Our moneys are being spent on several publications and educational opportunities, but how many take advantage of these?

Following these lectures at dinner we were assigned to sit with other president-elects covering districts approximately the same size as ours. This was followed by speeches, made by divisions of the Auxiliary, such as AMA-ERF, legislation and membership. Our new "Shape up for Life" program with advertisement was presented to us. This is a very exciting way of reaching the public.

Tuesday was another full day with seven topic seminars. Time only allowed us to hear three of these, however.

"Hospice Care in America" was given by Dennis Rexendes, Administrator of Hospice, Inc. in New Haven, Conn. where the first hospice was set up inthis country in February, 1974. Since there are now 125 Hospices in this country and 250 in the planning stages they will become more and more a part of tomorrow. Payments are the largest problem with Hospices as Mary Jo Gibson, Consultant for the US Department of Health, Education and Welfare, discussed.

One of the most informative seminars was "Marihuana and Children" by Robert L. DuPont, M.D., President of the Insitute for Behavior and Health, Bethesda, Maryland, and Clay Roberts, Health Education Coordinator, Educational Services, District #121, Seattle, Washington. Since the chemicals in marihuana are harmful to one's circulation, reproduction can be reduced, brain cell damage may occur and irritability is an effect, its wide use is frightening. Teachers and parents need to be educated concerning these problems.

"Health Maintenance" by Bill Hettler, M.D., Director, University Improvement Program at the University of Wisconsin, stressed that preventative medicine should be practiced. The usual cause of death now is chronic ailments, whereas in the 1900s it was infectious disease. After a show of hands we recognized that we all could improve our health by eating the right things and drinking less, exercising more, etc.

Althogether I thought that the 1979 Leadership Confluence was very informative and worthwhile. The national and state leaders taught me a great deal, while I shared many mutual ideas with fellow prisident-elects. □

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DR. RODKEY TELLS RATE SETTING COMMISSION PROPOSED RATES ARE UNACCEPTABLY LOW

Grant V. Rodkey, M.D., MMS President, testified recently at a public hearing held by the Massachusetts Rate Setting Commission at the State House on proposed rates of reimbursements for physicians. He told the Commission:

1. The proposed rates are unacceptably low and confiscatory.
2. There is no factual basis for the proposed rates.
3. There is no rational basis for setting the Workmen's Compensation rates at the same level as the Medicaid rates.
4. The period between rate determinations is unreasonably long.

In his testimony on the proposed rates for medical, surgical, and anesthesia care Dr. Rodkey stated:

"....I would like to review briefly the rates which are currently in effect for providers of Medicaid services and services under the Workmen's Compensation Act. In 1973, this Commission set the Medicaid and Workmen's Compensation rates at the 50th percentile of the 1970 Blue Shield usual and customary physician charges. In 1976, the Commission promulgated a new rate schedule. For the most part, the rates in the 1976 schedule were the same as the rates in the 1973 schedule, with the exception of minimum increases in a few proceedings. Later that year, the Legislature cut by 30% all Medicaid and Workmen's Compensation rates. That cut was rescinded in 1977, but only as to primary care services. Therefore, the 30% cut remains in effect for all non-primary care services.

Thus, for primary care services, the current rates are approximately the 50th percentile of the usual and customary Blue Shield physician charges in **1970**. For non-primary care services, the current rates are approximately 30% below the 50th percentile of the usual and customary Blue Shield physician charges in **1970**. Put another way, for primary care services, there has not been a rate increase over the 50th percentile of the customary fees prevailing in 1970, and for non-primary care services, there has actually been a 30% decrease since 1970. During this interval, the Boston Consumer Price Index has increased from 106.8 in 1970 to approximately 199.2 through November, 1978.

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In analyzing the rates proposed by the Commission it appears that the proposal is an average increase of approximately 7-8% for all fixed rate procedures. If the proposal were adopted by the Commission, the result would be that providers of primary care services would have received an increase of approximately 8 to 10% over the 8 year period from 1972 until 1980, and providers of non-primary care servies would have suffered a reduction of approximately 25% over that 8 year period. By a reasonable standard, that level of rates would fail to advance the purposes of the Medicaid program and for all intents and purposes would be confiscatory.

As you know, the purpose of the Medicaid program is to assure that people at lower income levels will be able to obtain necessary medical services. Section 32 of the General Laws, Chapter 6A, requires the Commission to set rates which are "fair, adequate, and reasonable." The rates should be high enough both to attract into the Medicaid program enough physicians to provide servies to eligible recipients, and to compensate physicians fairly for their efforts.

The available data indicates beyond a doubt that the rates currently in effect are so low as to dissuade large numbers of physicians from participating in the Medicaid program, and it is perfectly clear that an increase of approximately 7% does not begin to bring the rates to a level high enough to draw those physicians back into the program.

The percentage of physicians delivering services to Medicaid recipients is often viewed as a primary indicator of the effectiveness of the program. Although it appears that neither the Commission nor the Department of Public Welfare has precise data on physician participation rates, the DPW has estimates which are believed to be accurate to within a few percentage points. As I am sure you are aware, those estimates show that physician participation rates in the early 1970's were in the range of 70 to 80%, but those rates have been declining to the point where it now appears that only approximately 50% of the physicians licensed to practice medicine in Massachusetts submit any claims for Medicaid reimbursement in any calendar year.

Moreover, a large number of physicians submit only a few claims, so that it can fairly be said that considerably less than 50% of Massachusetts licensed physicians deliver a meaningful level of services to Medicaid recipients. In fact, only 4% of the medicaid expenditures in Massachusetts is paid out for physicians' services." □

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Yogi Berra once made a comment that would make a good motto for medical students. He said, "You can observe a lot just by watching."

HOWARD N. SIMPSON, M.D.

Observations

An animal feline
Known as domestic cat,
Will not good care decline
And be your darling pet.

But there's one thing he's got
(A virtue deep in roots)
Like dogs and men does not
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An Urgent Ethical Challenge

Medical ethics, like medicine itself steadily gains new dimensions and presents us with new challenges. Today, no challenge is greater or timelier than the deceleration of health-care costs. And it's truly an ethical challenge.

Considerateness for the bills that patients pay is integral to respecting patients as human beings. And that respect is where ethics begins.

Valuable guidance in carrying out the cost ethic is provided by the report of the National Commission on the Cost of Medical Care that the AMA sponsored.

All of us, and each of us, must take it upon ourselves to activate the Commission recommendations that have been approved by the AMA House of Delegates. We must make them an organic part of the daily consciousness and conduct of our profession.

Let's consider three of the recommendations as examples.

First, we must stimulate in our own ranks, in hopitals, and among our patients an effective realization of health-care costs and their impact on the system of care.

Second, we must urge intensified efforts to discipline those physicians who are found to be defrauding or abusing the health-care financing or delivery system. Also, we must enable more physicians to realize they have an ethical responsibility to report a colleague's misconduct. We cannot protect a wayward colleague without violating our own sworn duty to protect the patient.

Third, we must encourage intensified research toward a basic understanding of disease, and the most appropriate treatment thereof, within the context of today's urgent need for cost containment.

It must be stressed, however, that if we are to exert a maximum good influence on ethics and other growing issues, our Association must maximize its physicians representation from all segments of our profession.

Every physician in this land has a membership in the problems that the Association copes with in his or her behalf. So let's have fuller membership in the Association and its solutions. □

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AUXILIARY NEWS

Health Careers Scholarship Fund Campaign

As of this date - November 19, 1979 - we have received $2900 in contributions from members of the medical profession and their spouses in Hampden District. Our first Health Careers Scholarship Fund Campaign by mail has been an unquestionable success and we thank all of our supporters. The money you contributed will go toward scholarship awards to worthy students in allied health programs.

Because of rising costs and declining interest in the White Cap Ball as a social event, the Board voted in April, 1979, not to hold it this year. The questionnaire sent to our Auxiliary members a few months ago indicated strong support, however, for a scholarship fund campaign by mail instead. As a result of this campaign and your fine support we will again be able to give awards to deserving students in medically-related fields. (Pre-medical students are ex cluded).

Our scholarship awards are made on the basis of need, character, scholarship and aptitude Applicants must be residents of Hampden County and must be accepted by an accredited school.

To all those who contributed - THANK YOU!

To those who may not have contributed yet but would like to - there is still time. Your tax-deductible contribution may be made out to: Health Careers Scholarship Fund and mailed to Mrs. Francoise Pelletier,46 Atwater Terrace, Springfield, MA. 01107.□

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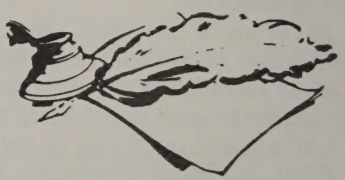
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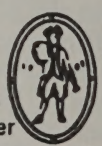
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Letter To The Editor

The Department of Public Welfare of the Commonwealth of Massachusetts has decided to require all physicians who wish to continue providing services under the MEDICAID program to reapply as welfare 'vendors'. This requirement, which will occur in early 1980, presents the medical profession with a tremendous opportunity, which should not be ignored, to influence the regulative process.

During the past ten years the Department of Public Welfare has slowly developed a program which is insulting, demeaning, fiscally irresponsible, and incompatible with good medical care. Up till the present we have accepted these inequities using the excuse that we did not know or understand the myriad technicalities of the program, and have limited our actions to ineffectual grumbling about fee schedules. Now we are in a position where we must actively reapply for 'vendor status. By reapplying each and every one of us will infer detailed knowledge and acceptance of the details of the program, which are being provided to us all. In transmittal letter ALL-2 dated November 1979 we are told' **It is urged that you familiarize yourself with these regulations as soon as possible.'**

I suggest that the most effective action we can take is for all physicians to refuse to reapply for 'vendor' status. If no medical providers become available the state can not meet it's obligations under Title XIX of the Social Security Amendments of 1965 (P.L. 89-97). With no physician manpower available to the program we could then bargain effectivelyf or a fair and reasonable contract. Remember that we are being asked to sign a contract to supply services. It is no different than a company or union signing a contract which it then must honor. The beauty of the situation is that no one could play politics by accusing us of resigning from the system. We would merely be declining to sign an unacceptable contract.

Read the revised administrative and billing regulations of the D.P.W. **carefully.** Notice the restrictions placed upon you. Look thoroughly at the sanctions and penalties that can be applied by bureaucrats and political figures trying to further their own careers. Balance these with the rewards, financial and other, which accrue from the program. Remember the present fee schedule, drawn up in 1974 and based on 1971 statistics? Is it worth the inconvience and temporary loss of income involved in a policy of non cooperation for six months or a year to force a more equitable contract? I believe it is.

Remember, the politicians respond to the squeaky wheel. So lets apply pressure while we can. Once we all sign up it will be too late because no one will listen to us! □

JOHN D. IZSAK, M.D.

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